

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
ISM 9/59

4124
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04118

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 23 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 1105 Parrish Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Peter Middle (NMI) Last Arnone		4. DATE OF DEATH Month April Day 26 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown 1874 9. AGE (In years last birthday) 87 yrs. IF UNDER 1 YEAR Months 88 Days 88 Hours 88 Min. 88
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Industry	11. BIRTHPLACE (State or foreign country) Italy 12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown FRANK ARNONE		14. MOTHER'S MAIDEN NAME Unknown ROSE unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. NONE - 17. INFORMANT Springfield Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal bronchopneumonia DUE TO 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S.assoc. with cerebral arteriosclerosis with psychotic reaction.			INTERVAL BETWEEN ONSET AND DEATH Days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 3, 1961 to April 26, 1961 that (I) (we) last saw the deceased alive on April 25, 1961 , and that death occurred at 2 AM , from the causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo 22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22b. DATE SIGNED 4/26/61 ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22d. ADDRESS Springfield Hospital, Sykesville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 4/28/61	23c. NAME OF CEMETERY OR CREMATORY ST. MICHAEL'S CEMETERY	23d. LOCATION (City, town, or county) (State) FROSTBURG, MARYLAND
24. FUNERAL DIRECTOR'S SIGNATURE WAGNER E. PUMPHREY, INC. Raymond A. Jiska		25a. REC'D BY REGISTRAR DATE MAY 2 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Kiana

ADDRESS
SILVER SPRING, MD.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

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1
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

4125

04119

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Washington ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN 1b 12yr. 7mos. 15das. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Grover Middle Cleveland Last Artz | | | | 4. DATE OF DEATH
Month April Day 3 Year 1961 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH October 4, 1892 | |
| 9. AGE (In years last birthday) 68 yrs. | | IF UNDER 1 YEAR
Months 0 Days 0 | | IF UNDER 24 HRS.
Hours 0 Min. 0 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry truck driver | | | | 10b. KIND OF BUSINESS OR INDUSTRY Laundry | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Charles C. Artz | | | | 14. MOTHER'S MAIDEN NAME Carrie C. Wade | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | | | 16. SOCIAL SECURITY NO. 214-09-4845 | | 17. INFORMANT Springfield Records. Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia
DUE TO (b) 491X
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with syphilitic meningo-encephalitis. | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH Days | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from March 7, 1955 to April 3, 1961 , that (I) (we) last saw the deceased alive on April 3, 1961 , and that death occurred 4:25PM from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Agustin del Campo M.D. | | | | 22b. DATE SIGNED 4/3/61 | | | |
| 22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. | | | | 22d. ADDRESS Springfield Hospital, Sykesville, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 4-6-61 | | 23c. NAME OF CEMETERY OR CREMATORY Freedom | | 23d. LOCATION (City, town, or county) (State) Sykesville, Carroll Co., Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Arthur W. Haight ADDRESS Sykesville, Md. | | | | 25a. REC'D BY REGISTRAR APR 7 '61 DATE | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

01119

CERTIFICATE OF DEATH

1913

(M)

1
 4126
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH
 04120

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
o. COUNTY <u>CARROLL</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>MARYLAND</u> b. COUNTY <u>—</u> ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL Sykesville</u> | | c. LENGTH OF STAY IN 1b <u>3 WEEKS</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GOLDEN AGE GUEST HOME</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Anna Louisa BENSEL</u> | | 4. DATE OF DEATH Month Day Year <u>April 6, 1961</u> | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JANUARY 16, 1887</u> 74 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u> | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>BERNARD BURK</u> | |
| 14. MOTHER'S MAIDEN NAME <u>CHRISTINA ZELLER</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | |
| 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT <u>Mrs. Augusta Vinger</u> Address <u>143 WILLARD ST.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>332X</u> DUE TO <u>Cerebral Embolism</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Senile Arterio Sclerosis</u> DUE TO <u>hypertension</u>
(c) <u>Cardiohypertrophy</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u> | 20f. (City or town) (County) (State) <u>—</u> |
| 21. I certify that (I) (this hospital) attended the deceased from <u>March 2, 1961</u> to <u>April 6, 1961</u> , that (I) (we) last saw the deceased alive on <u>April 6, 1961</u> , and that death occurred on <u>April 6, 1961</u> M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Donald R. Mastin</u> M.D. | | 22b. DATE SIGNED <u>APR 11 '61</u> | |
| 22c. PHYSICIAN'S NAME (Type or print) <u>DOUGLAS R. MASTIN</u> | | 22d. ADDRESS <u>Sykesville Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE THEREOF <u>4-10-61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>London Park</u> | 23d. LOCATION (City, town, or county) (State) <u>BALTIMORE Md.</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Geo. L. Schwab, Funeral Home</u> ADDRESS <u>2101 Frederick Ave. Balto., Md.</u> | | 25a. REC'D BY REGISTRAR <u>—</u> DATE <u>APR 11 '61</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>—</u> | | 25c. REGISTRAR'S NAME <u>—</u> | |

0113H

CERTIFICATE OF DEATH

1130

(M)

Coroner

1. Name of deceased

2. Age

3. Sex

4. Date of death

5. Place of death

6. Cause of death

7. Manner of death

8. Signature

9. Date

10. Place

11. Signature

12. Date

13. Place

14. Signature

15. Date

16. Place

17. Signature

18. Date

CERTIFICATE OF DEATH

Reg. Dist. No.

04121

4127

| | | | | | | | |
|--|---------------------------|--|--------------------------------------|--|--|---|------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Dunnell</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Dunnell</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> | | | | c. LENGTH OF STAY IN 1b <u>1 year</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u> | | | | d. STREET ADDRESS <u>348 Greene St</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>MARY-FARR-BOERNER</u> First Middle Last | | | | 4. DATE OF DEATH <u>April 27</u> 19 <u>61</u> Month Day Year | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>March 3-1877</u> | | 9. AGE (In years last birthday) <u>84</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Refused</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John Gibson</u> | | | | 14. MOTHER'S MAIDEN NAME <u>SARAH HUGHES</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>No</u> | | 17. INFORMANT <u>Mrs. Elmer Snyder - Westminster, Md</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary infarction</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary embolus</u> DUE TO (c) <u>2 hrs</u>
INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Myasthenia Gravis</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Oct 1, 1960</u> , to <u>April 27, 1961</u> , that I last saw the deceased alive on <u>April 27, 1961</u> , and that death occurred at <u>6:45 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Julius Chepko</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>854 W. Green St</u> | | DATE SIGNED <u>4/27/61</u> | |
| PHYSICIAN'S NAME (Type) <u>Julius Chepko</u> | | | | <u>Westminster Md</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>April 29/61</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>St Paul Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edwin E. Hampton</u> ADDRESS <u>Hampstead Md</u> | | | | 24. REC'D BY REGISTRAR <u>APR 28 1961</u> DATE | | 24b. REGISTRAR'S SIGNATURE <u>Robert S. Thomas</u> | |

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

4128

04122

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Howard | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural--Sykesville | | | | c. LENGTH OF STAY IN 1b
35y. 5m. 26d. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Florence | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Springfield State Hospital | | | | d. STREET ADDRESS
-- | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Marian Middle - Last Bowie (Buoy) | | | | 4. DATE OF DEATH
Month 4 Day 12 Year 1961 | | | |
| 5. SEX
female | | 6. COLOR OR RACE
white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Duvall
1/28/87 | |
| 9. AGE (In years last birthday)
74 yrs. | | 10. IF UNDER 1 YEAR
Months 4 Days 12 Hours 19 Min. | | 11. IF UNDER 24 HRS.
Months 4 Days 12 Hours 19 Min. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housework | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Maryland | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
Charles Duvall | | | | 14. MOTHER'S MAIDEN NAME
Ruth Lentz | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
no | | 17. INFORMANT Springfield State Hospital records | | Address Sykesville, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia
DUE TO Chronic degenerative hyocarditis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 422.01
DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mental deficiency, undifferentiated. | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. 19
p. m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct. 16, 1925 to 4/12, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 4/12, 1961 , and that death occurred at 2:50 AM , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<i>Konstantin Weber</i> | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
Konstantin Weber, M. D. | | | | 22d. ADDRESS Springfield State Hospital Sykesville, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) (State) | |
| 4-13-C1 | | 4-13-61 | | Wm. Anstey Board | | Baltimore, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<i>Frank H. Hunsell</i> | | | | ADDRESS
<i>Pikes & mci</i> | | 25a. REC'D BY REGISTRAR
DATE APR 14 '61 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
<i>William L. Hunsell</i> | |

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CHINA

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MEDICAL CERTIFICATION

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1321

4129

04123

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|---|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Carroll | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland
b. COUNTY Montgomery Co. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville | | c. LENGTH OF STAY IN 1b
10mths, 21 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Springfield State Hospital. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Mary (Mamie) Middle Bird Last Bowman | | 4. DATE OF DEATH
Month April Day 22 Year 1961 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
6-25-1885 |
| 9. AGE (In years lost birthday) yrs. 75 | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 11b. KIND OF BUSINESS OR INDUSTRY | |
| 12. BIRTHPLACE (State or foreign country)
Maryland | | 13. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 14. FATHER'S NAME
James W. Boyer | | 15. MOTHER'S MAIDEN NAME
Alice Lewis | |
| 16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 17. SOCIAL SECURITY NO.
--- | |
| 18. INFORMANT
Hospital records | | 19. Address
Sykesville, Maryland. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease.
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease, with psychotic reaction. | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour a. m. p. m. Month, Day, Year
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 6-2-1960 to 4-22-1961 , that (I) (we) last saw the deceased alive on 4-22-1961 , and that death occurred 10.45 P. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Agustin del Campo M.D. | | 22b. DATE
April 23 | |
| 22c. PHYSICIAN'S NAME (Type)
Agustin del Campo M.D. | | 22d. ADDRESS
Springfield State Hospital, Sykesville, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4/26/61 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Salem Meth. | | 23d. LOCATION (City, town, or county) (State)
Cedar Grove, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Olin L. Wolanin | | 25a. REC'D BY REGISTRAR
DATE APR 25 '61 | |
| ADDRESS
Damascus, Md. | | 25b. REGISTRAR'S SIGNATURE
Arthur L. Hines | |



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

| | | | | | | | |
|--|----------------------------------|---|--|--|---|---|--------------------------------|
| 4130 | | Item 14 Film 0285 | | 4/24/61 ink | | 04124 | |
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Carroll | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Union Mills | | c. LENGTH OF STAY IN lb
several yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Westminster | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Meadow View Convs. Home | | | | d. STREET ADDRESS
76 Bond Street | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Caroline Elizabeth Carlisle | | | | 4. DATE OF DEATH
Month April Day 13 Year 1961 | | | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Oct. 10, 1871 | | 9. AGE (In years last birthday)
89 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John Miller | | | | 14. MOTHER'S MAIDEN NAME
Mary Bosenbury | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
-- | | 16. SOCIAL SECURITY NO.
--- | | 17. INFORMANT
Mrs. Chas. T. Eunick | | Address
76 Bond St. Westminster, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ARTERIO SCLEROTIC C-V DISEASE
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1953 to 4-13 , 19 61 , that (I) (we) last saw the deceased alive on 4-10 , 19 61 , and that death occurred at 2 A M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
James J. Marsh | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
4/13/61 | |
| 22c. PHYSICIAN'S NAME (Type)
JAMEST MARSH | | | | 22d. ADDRESS
Westminster Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4/15/61 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Thomas Cemetery | | 23d. LOCATION (City, town, or county) (State)
Owings Mills, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
J.F. Eline & Sons, Reisterstown, Md. | | | | 25a. REC'D BY REGISTRAR
DATE APR 18 '61 | | 25b. REGISTRAR'S SIGNATURE
Arthur L. Kline | |

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Dr. Charles T. Emdin

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
4131
CERTIFICATE OF DEATH
04125

| | | | | |
|---|----------------------------------|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Carroll | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Woodbine | | c. LENGTH OF STAY IN 1b
Life | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print)
VIOLA C. CONDON | | 4. DATE OF DEATH
Month APRIL Day 16 Year 1961 | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
March 16, 1895 | |
| 9. AGE (In years last birthday)
66 yrs. | | 10. IF UNDER 1 YEAR
Months 66 Days 66 Hours 66 Min. 66 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Domestic | | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | |
| 13. FATHER'S NAME
Richard Evans | | 14. MOTHER'S MAIDEN NAME
Rhoda Colison | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
***** | | 16. SOCIAL SECURITY NO.
***** | | |
| 17. INFORMANT
Mr. Augustus Condon, Woodbine, Maryland | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Malignant Lymphoma - retro
200.2 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) pentoned - Anemia - Cardiac
(c) failure - | | | | INTERVAL BETWEEN ONSET AND DEATH
1560
to
16 April 61 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 1960 12, to 16 April 1961 , that (I) (we) last saw the deceased alive on 16 April 1961 , and that death occurred at 16 April 1961 M, from the causes and on the date stated above. | | | | |
| 22a. SIGNATURE
Howard E. Hall | | 22b. DATE SIGNED
16 April 61 | | |
| 22c. PHYSICIAN'S NAME (Type)
Howard E. Hall, M. D. | | 22d. ADDRESS
Aghenville, Md 16 April 61 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4-19-1961 | | |
| 23c. NAME OF CEMETERY OR CREMATORY
Morgan Chapel Cemetery | | 23d. LOCATION (City, town, or county) (State)
Carroll Co., Maryland | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
C. M. Waltz, Winfield, Maryland | | 25a. REC'D BY REGISTRAR
DATE APR 18 '61 | | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Hous | | | | |

CERTIFICATE OF DEATH

1911

Carroll

Carroll

Life

Woodbury

Carroll

Carroll

1901

1901

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1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
4132 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04126

| | | | | | | | |
|---|--|--|--|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>CARROLL Co</u> <u>Maryland</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Sykesville</u> Rural | | c. LENGTH OF STAY IN 1b
<u>life</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Rural--Sykesville</u> R. D. <u>2</u> | | d. STREET ADDRESS
<u>Streaker Road</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Earl</u> Middle <u>Columbus</u> Last <u>Costley</u> | | | | 4. DATE OF DEATH
Month <u>April</u> Day <u>27</u> Year <u>1961</u> | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>Negro</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Jan.-27, 1929</u> | |
| 9. AGE (If years last birthday)
<u>32</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Laborer</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | |
| 13. FATHER'S NAME
<u>Raymond I. Costley</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Alverta Myers</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>Yes</u> | | 16. SOCIAL SECURITY NO.
<u>215-28-6308</u> | | 17. INFORMANT
<u>Raymond I. Costley, Sykesville, Md.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Gunsled wound of chest</u>
981X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO (b)
DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour <u>a.m.</u> <u>19</u>
p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
<u>William V. Lovitt</u> | | EXAMINER'S NAME (Type)
<u>William V. Lovitt, M. D.</u> | | M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED
<u>4/27/61</u> | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>4-30-1961</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Fairview Cemetery</u> | | 22d. LOCATION (City, town, or country) (State)
<u>Carroll Co., Maryland</u> | |
| 23. FUNERAL DIRECTOR
<u>C. M. Waltz, Winfield, Maryland</u> | | | | 24. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Hines</u> | | | |

4133

DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04127

| | | | | | | | |
|---|----------------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Carroll</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> COUNTY <u>Carroll</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Westminster</u> | | c. LENGTH OF STAY IN 1b
<u>86 yrs.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Westminster 27</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>14 Bond St.</u> | | | | d. STREET ADDRESS
<u>14 Bond St. 1</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>EDWARD</u> Middle <u>OLIVER</u> Last <u>DIFFENDAL</u> | | | | 4. DATE OF DEATH
Month <u>APRIL</u> Day <u>20</u> Year <u>1961</u> | | | |
| 5. SEX
<u>male</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Oct. 9, 1874</u> | 9. AGE (In years last birthday)
<u>86</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>retired editor & manager of a printing Co.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Westminster, Md. U.S.A.</u> | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
<u>Joseph Diffendal</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Mary Martin</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO.
<u>214-01-0694</u> | | 17. INFORMANT
<u>Mrs. E. O. Diffendal, Same address</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial infarction</u>
443X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>hypertension</u> DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 yrs.</u>
<u>3 yrs.</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>May 1955</u> to <u>Apr 20, 1961</u> , that (I) (we) last saw the deceased alive on <u>Apr 17, 1961</u> , and that death occurred at <u>8:00 PM</u> , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>W. C. Jesmide</u> | | | | 22b. DATE
<u>4-28-61</u> | | 22c. PHYSICIAN'S NAME (Type)
<u>W. C. Jesmide</u> | |
| 22d. ADDRESS
<u>Westminster Md.</u> | | | | 22e. ADDRESS
<u>Westminster Md.</u> | | 22f. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>4/22/61</u> | | <u>Madison Branch</u> | | <u>rural Westminster, Md.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>J. E. Myers, Jr., Westminster, Md.</u> | | | | 25a. REC'D BY REGISTRAR
DATE <u>APR 25 '61</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles E. Hume</u> | |

TO HOSPITAL OR FUNERAL PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 1 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(I)

Dependent, Ch. H. Ch.
1/10/1911

3/11
3/11

1/10/1911
1/10/1911
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1/10/1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

4134

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4134

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04128

| | | | |
|---|----------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville
c. LENGTH OF STAY IN 1b
1 mos. 8 das.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Springfield State Hospital | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore
d. STREET ADDRESS
3333 Clifftmont Ave.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Bettie Earhart | | 4. DATE OF DEATH
Month Day Year
April 14 1961 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6-4-69 |
| 9. AGE (In years last birthday)
91 yrs. | | IF UNDER 1 YEAR
Months Days
IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
- | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Oliver Collins | | 14. MOTHER'S MAIDEN NAME
Frances Pletzer | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
212-14-8788 | |
| 17. INFORMANT
Springfield Medical Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute pulmonary edema
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
INTERVAL BETWEEN ONSET AND DEATH
hours
years | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 3-6-1961 to 4-14-1961 that (I) (we) last saw the deceased alive on 4-14-1961 , and that death occurred at 5 A.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Agustin del Campo
22c. PHYSICIAN'S NAME (Type)
Agustin del Campo, M.D. | | 22b. DATE SIGNED
April 14, 1961
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | |
| 22d. ADDRESS
Springfield Hospital, Sykesville, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4/17/61 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | | 23d. LOCATION (City, town, or county) (State)
Baltimore, Md. (Woodlawn) | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Charles E. Schimunek
ADDRESS
3331 Brehms Lane | | 25a. REC'D BY REGISTRAR
DATE APR 17 '61 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | |

UNIT 3

CERTIFICATE OF DEATH

1138

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04129

| | | | |
|---|-------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Carroll Co.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> | | c. LENGTH OF STAY IN 1b <u>60 yrs</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>317 E. Main St.</u> | | d. STREET ADDRESS <u>317 E. Main St.</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>CATHERINE ORETTA ECKARD</u> | | 4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>1961</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct. 10, 1879</u> |
| 9. AGE (In years lost birthday) <u>83</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>States N. Dell</u> | | 14. MOTHER'S MAIDEN NAME <u>Sarah Ann Breighner</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Mr. John R. Schaud</u> | | Address <u>Westminster Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial (Chr) Hypertension (cardi)</u>
422.2 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>May 1955</u> to <u>April 20, 1961</u> , that (I) (we) last saw the deceased alive on <u>Apr 22 1961</u> , and that death occurred at <u>5P</u> M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Wm C. Jermette</u> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>Wm Carl Jermette</u> | | 22d. ADDRESS <u>103 E Main Westminster Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>4/26/61</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>Westminster Md.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Meyers, Jr.</u> | | 25a. REC'D BY REGISTRAR <u>APR 28 '61</u> | |
| ADDRESS <u>Westminster Md.</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u> | |

10151

CERTIFICATE OF MARRIAGE

1133



Married at (City) N. York (date)

Wed 22 - June 21

102 E Main Rochester NY

Wm. G. Bennett
Rev. J. J. Bennett
Rev. J. J. Bennett

4136

| | | | | |
|---|-------------------------------------|--|---|---|
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
<i>Burial</i> | 23b. DATE THEREOF
<i>4/11/61</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>Not Known</i> | 23d. LOCATION (City, town, or county)
<i>Beth Md</i> | (State) |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<i>Wm. Gable Hayes</i> | | ADDRESS
<i>Beth. Md</i> | 25a. REC'D BY REGISTRAR
DATE <i>APR 10 '61</i> | 25b. REGISTRAR'S SIGNATURE
<i>Wm. G. Hayes</i> |

VR A15 (4)
ISM 9/59

Remains 4/10/61 The balance
- No one else's things But not

But not

Wm. B. Davis

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4137

Item 2 Film 0287 5/16/61 mb

04131

| | | | | | | | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <i>Carroll</i> | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lylesville</i> | | c. LENGTH OF STAY IN 1b <i>16 days</i>
<i>in J.S.H.</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>Pa.</i> | | b. COUNTY <i>Bedford</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>EVERETT, PA</i> | | d. STREET ADDRESS <i>6K Ave</i> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <i>JAMES</i> Middle <i>WALTER</i> Last <i>FEIGHT</i> | | 4. DATE OF DEATH <i>4</i> Month <i>2</i> Day <i>1961</i> | | 5. SEX <i>male</i> | | 6. COLOR OR RACE <i>white</i> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>10-9-1902</i> | | 9. AGE (In years last birthday) <i>58</i> yrs. | | 10. IF UNDER 1 YEAR
Months <i>5</i> Days <i>8</i> Hours <i>15</i> Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>paper at Swift Co</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>unknown</i> | | 11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 13. FATHER'S NAME <i>Henry A. Feight</i> | | 14. MOTHER'S MAIDEN NAME <i>Mary E. Segal</i> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>unknown</i> | | 16. SOCIAL SECURITY NO. <i>unknown</i> | | | |
| 17. INFORMANT <i>Hospital staff starting 3-27-1965</i> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Coronary Myocardial insufficiency</i>
355X DUE TO <i>CBS of unknown origin</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Huntington's disease</i>
DUE TO (c) <i>Huntington's disease</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i>
<i>a bad patient</i> | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>antemortem permission was not granted by wife</i> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year
Hour a. m. <i>19</i> p. m. <i>19</i> | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/>
of work <input checked="" type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Springfield State Hospital</i> | | 20f. (City or town) <i>Springfield</i> | | (County) <i>Bedford</i> | | (State) <i>Pa</i> | | 21. I certify that (I) (this hospital) attended the deceased from <i>3-27</i> <i>1965</i> , to <i>4-2</i> <i>1961</i> , that (I) (we) last saw the deceased alive on <i>4-1</i> <i>1961</i> , and that death occurred at <i>8:34</i> M, from the causes and on the date stated above. | | 22a. SIGNATURE <i>Heinz H. Klaatseh</i> | | 22b. DATE SIGNED <i>4-2-61</i> | | 22c. PHYSICIAN'S NAME (Type) <i>HEINZ H. KLAATSCH</i> | | 22d. ADDRESS <i>Springfield State Hospital</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE THEREOF <i>4-5-61</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Everett Cemetery</i> | | 23d. LOCATION (City, town, or county) <i>Everett, Bedford Co, Pa</i> | | (State) <i>Pa</i> | | 24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Kraus</i> | | 25a. REC'D BY REGISTRAR <i>APR 5 '61</i> | | 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> | | 25c. DATE <i>APR 5 '61</i> | |

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RECEIVED
OFFICE OF THE
DIRECTOR OF THE
BUREAU OF THE
CENSUS
WASHINGTON, D.C.

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TO HOSPITAL OR FUNERAL PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4138

CERTIFICATE OF DEATH

04132

| | | | | | |
|--|----------------------------------|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY CARROLL MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY CITY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural - Sykesville | | c. LENGTH OF STAY IN 1b
lmo 27 days | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
SPRINGFIELD STATE HOSPITAL | | | d. STREET ADDRESS
4215 Sheldon Avenue | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First JOSEPH Middle MICHAEL Last FLORIN | | | 4. DATE OF DEATH
Month 4 Day 3 Year 19 61 | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3-20-79 | | 9. AGE (In years lost birthday) 82 yrs.
IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS: Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Boiler contractor | | 10b. KIND OF BUSINESS OR INDUSTRY
----- | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
Frank Florin | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | |
| 14. MOTHER'S MAIDEN NAME
Sophia (unknown) | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
NO | | 16. SOCIAL SECURITY NO.
215-32 2785 | | 17. INFORMANT
HOSPITAL RECORDS | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchial Pneumonia
DUE TO
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Myocardial insufficiency
DUE TO
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with cerebral arteriosclerosis with psychosis | | | | | INTERVAL BETWEEN ONSET AND DEATH
4 days

years |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that (I) (this hospital) attended the deceased from 2/6/61 to 4/3/61 , 19____, that (I) (we) last saw the deceased alive on 4/3/61 , 19____, and that death occurred at 7:05AM , from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
Gertrude M. Gross, M.D. | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 4/3/61 | | 22b. DATE SIGNED |
| 22c. PHYSICIAN'S NAME (Type)
Gertrude M. Gross, M.D. | | | 22d. ADDRESS
Springfield State Hospital | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
4/6/61 | | 23c. NAME OF CEMETERY OR CREMATORY
HOLY REDEMER | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
D. PPEL BROS | | ADDRESS
1800 E. Lombard St | | 25a. REC'D BY REGISTRAR
DATE APR 4 '61 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

CERTIFICATE OF DEATH

1922

17

| | | | | | | | | | |
|-------------------|--|----------------------|--|------------------------|--|------------------------|--|------------------------|--|
| Name of Deceased | | Age | | Sex | | Race | | Religion | |
| Date of Death | | Place of Death | | Cause of Death | | Disease | | Signature of Physician | |
| Date of Burial | | Place of Burial | | Name of Minister | | Name of Undertaker | | Signature of Minister | |
| Name of Informant | | Address of Informant | | Signature of Informant | | Signature of Registrar | | Signature of Coroner | |



VR A15 (4)
ISM 9/59

04133

| | | | | | | | |
|--|---|---|-------------------------------------|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Carroll</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY _____ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>rural) Sykesville</u> | | c. LENGTH OF STAY IN 1b
<u>29y.3mo.18d.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore</u> | | d. STREET ADDRESS
<u>unknown</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Springfield State Hospital</u> | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) <u>Oliver</u> | | First Middle Last
<u>- Foble (Fauble)</u> | | 4. DATE OF DEATH
Month <u>4</u> Day <u>5</u> Year <u>1961</u> | | | |
| 5. SEX
<u>male</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>11-13-97</u> | | 9. AGE (In years last birthday)
<u>63</u> yrs. | IF UNDER 1 YEAR
Months _____ Days _____ | IF UNDER 24 HRS.
Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>---</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Joshua Foble (Fauble)</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Lena Constantine</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>unknown</u> | | 16. SOCIAL SECURITY NO.
<u>---</u> | | 17. INFORMANT
<u>Springfield State Hospital Records</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Chronic Congestive Heart Disease</u>
<u>527.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Aortic insufficiency. Auricular Fibrillation</u>
DUE TO (c) <u>Emphysema</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>more than one year</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mental defective with epilepsy-type of epilepsy unknown</u> | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. _____ p. m. _____
<u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>9-60</u> to <u>4-5-</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>4-5-</u> <u>1961</u> , and that death occurred at <u>7:40 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Yasuo Takahashi</u> | | | | 22b. DATE SIGNED
<u>4-5-1961</u> | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Yasuo Takahashi, M.D.</u> | | | | 22d. ADDRESS
<u>Springfield State Hospital</u>
<u>Sykesville, Maryland</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Removal</u> | 23b. DATE THEREOF
<u>4-7-61</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Anatomy Board</u> | | 23d. LOCATION (City, town, or county) (State)
<u>Baltimore Md.</u> | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>Frank H. Newell</u> | | | | 25a. REC'D BY REGISTRAR
<u>APR 12 '61</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Arthur L. Kline</u> | |

5010

WATKINS & WATKINS

113



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **04135**

4140

| | | | | | |
|---|---|--|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Virginia b. COUNTY Loudoun | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Mount Airy-Rural | | | c. LENGTH OF STAY IN 1b
2 Years | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Day Nursing Home | | | d. STREET ADDRESS
83X-3 | | |
| 3. NAME OF DECEASED (Type or print)
First NELLIE Middle E. Last GEORGE | | | 4. DATE OF DEATH
Month April Day 24 Year 1961 | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6 Nov 1878 | | 9. AGE (In years last birthday) yrs. 82 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House-work | | 10b. KIND OF BUSINESS OR INDUSTRY
At Home | 11. BIRTHPLACE (State or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
Robert L. George | | | 14. MOTHER'S MAIDEN NAME
Florence Near | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO.
None | 17. INFORMANT Address
Mrs. Robert Riddlemoser, Lovettsville, Va. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) General debility with Chronic Poisoning
794X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. _____ p. m. _____ 19 _____ | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that I attended the deceased from Jan , 19 49 , to Apr 24 , 19 61 , that I last saw the deceased alive on Apr 23 , 19 61 , and that death occurred at 7:10 P.M. from the causes and on the date stated above. | | | | | |
| ACTUAL SIGNATURE
C. M. Van Rabe | | ADDRESS (Street, city or town, state)
Mt Airy Rd | | DATE SIGNED
4-24-61 | |
| PHYSICIAN'S NAME (Type)
C. M. Van Rabe | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
4-26-61 | 22c. NAME OF CEMETERY OR CREMATORY
Reformed Cemetery | | 22d. LOCATION (City, town, or county) (State)
Lovettsville, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
M. R. Etchison & Son, Frederick, Maryland | | ADDRESS
Frederick, Maryland | | 24a. REC'D BY REGISTRAR
APR 26 '61 | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kneass |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

4141
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04134

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville | | c. LENGTH OF STAY IN 1b
3mos.13days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Springfield State Hospital | | d. STREET ADDRESS
913 Fairway Drive | |
| 3. NAME OF DECEASED (Type or print)
First William Middle Roszell Last German | | 4. DATE OF DEATH
Month April Day 17 Year 1961 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
March 11, 1898 |
| 9. AGE (In years last birthday)
63 yrs. | | IF UNDER 1 YEAR
Months 63 Days 17 Hours 19 Min. 61 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Owner of Transfer Co. | | 10b. KIND OF BUSINESS OR INDUSTRY
- | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Thomas German | | 14. MOTHER'S MAIDEN NAME
Belle Price | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
1st world war. | | 16. SOCIAL SECURITY NO.
216-07-0254 | |
| 17. INFORMANT
Springfield Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Suppurative nephritis
DUE TO
(c) Acute gangrenous cellulitis of the scrotum | | INTERVAL BETWEEN ONSET AND DEATH
Days
Weeks
Weeks | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
C.B.S.assoc.with cerebral arteriosclerosis without qualifying phrase. | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from January 4, 1961 to April 17, 1961 , that (I) (we) last saw the deceased alive on April 16, 1961 , and that death occurred 12:03AM from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Agustin del Campo M.D. | | 22b. DATE SIGNED
4/17/61 | |
| 22c. PHYSICIAN'S NAME (Type)
Agustin del Campo, M.D. | | 22d. ADDRESS
Springfield Hospital, Sykesville, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
4-20-61 | | 23b. DATE THEREOF | |
| 23c. NAME OF CEMETERY OR CREMATORY
ST JAMES EPI. Cem. | | 23d. LOCATION (City, town, or county) (State)
MONKTON - Md | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Lemard Gluck ADDRESS 5305 Bayford Rd | | 25a. REC'D BY REGISTRAR
APR 20 '61 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Kline | | | |

STATE OF NEW YORK
COUNTY OF ALBANY
JANUARY 10, 1907

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Henryton State Hosp. | | c. LENGTH OF STAY IN 1b
28 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Henryton State Hospital | | d. STREET ADDRESS
Rt. #1, Box 247 | |
| e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First James Middle Robert Last Hackley | | 4. DATE OF DEATH
Month April Day 17 Year 1961 | |
| 5. SEX
Male | 6. COLOR OR RACE
Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
January 23, 1914 |
| 9. AGE (In years lost birthday)
47 yrs. | | IF UNDER 1 YEAR
Months 47 Days 17 Hours 19 Min. 61 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Elevator Operator | | 10b. KIND OF BUSINESS OR INDUSTRY
Cannonsburgh, Penna. | |
| 11. BIRTHPLACE (State or foreign country)
U. S. A. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Charles F. Hackley | | 14. MOTHER'S MAIDEN NAME
Mable Brown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
225-10-1957 | |
| 17. INFORMANT
James R. Hackley-Patient | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cor Pulomonale and Heart failure
DUE TO (b) Moderately advanced bilateral pulmonary
DUE TO (c) Tuberculosis + left surgery. Bilat. fibrosis
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0027 | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from March 20, 1961 to April 17, 1961 , that (I) (we) last saw the deceased alive on April 17, 1961 , and that death occurred at 1:45 A.M. from the causes and on the date stated above. | | 22a. SIGNATURE
Edgars M. Maculans, M.D. | |
| 22c. PHYSICIAN'S NAME (Type)
Edgars M. Maculans, M.D. | | 22b. DATE SIGNED
4-17-61 | |
| 22d. ADDRESS
Henryton State Hospital, Henryton, Md. | | 22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4-20-61 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Harmony Mem Park | | 23d. LOCATION (City, town, or county) (State)
Highland Park Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Smittle R. Rollins | | 25a. REC'D BY REGISTRAR
APR 20 '61 | |
| 25b. REGISTRAR'S SIGNATURE
Carlton S. House | | 25c. ADDRESS
4339 Hunt Pl | |

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 5/59

1
4143
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04137

| | | | |
|---|---------------------------|--|------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <i>Carroll</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Eldersburg</i> | | c. LENGTH OF STAY IN 1b <i>20 yrs</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Golden Age Conv. Home</i> | | d. STREET ADDRESS <i>3207 Southern Ave.</i> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <i>Nellie</i> Middle <i>HANTHORN</i> Last <i>HANTHORN</i> | | 4. DATE OF DEATH Month <i>4</i> Day <i>26</i> Year <i>1961</i> | |
| 5. SEX <i>F</i> | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>1872</i> |
| 9. AGE (In years lost birthday) <i>89</i> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | |
| 13. FATHER'S NAME <i>Charles P. T. Hanthorn</i> | | 14. MOTHER'S MAIDEN NAME <i>Mary P. A. Dawson</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>P</i> | |
| 17. INFORMANT <i>Signa E. Talbot, Rt 2 Sykesville</i> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i>
<i>331X</i> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Long Anterior Sclerosis</i>
(c) <i>Hypertension</i> | | INTERVAL BETWEEN ONSET AND DEATH
<i>2 days</i>
<i>2 yrs</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>April 24th</i> 19 <i>61</i> , to <i>April 26th</i> 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>April 25th</i> 19 <i>61</i> , and that death occurred at <i>2:00 PM</i> , from the causes on and on the date stated above. | | | |
| 22a. SIGNATURE <i>Horrell H. Mastin M.D.</i> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <i>MORRELL H. MASTIN</i> | | 22d. ADDRESS <i>Sykesville Md</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE THEREOF <i>4-28-61</i> | |
| 23c. NAME OF CEMETERY OR CREMATORY <i>Louisa Park</i> | | 23d. LOCATION (City, town, or county) (State) <i>Balto, Md.</i> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>Louisa Funeral Home</i> | | ADDRESS <i>7401 Belair Rd</i> | |
| 25a. REC'D BY REGISTRAR <i>MAY 1 '61</i> | | 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i> | |

CERTIFICATE OF DEATH

1113

1

Given

Edinburgh

Given at Edinburgh

Married

Name

Charles

Johnston

Johnston

Johnston

Johnston

Johnston

Johnston



8

Johnston

Johnston

Johnston

Johnston

Johnston

Johnston

Johnston

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4144

Items 1c & 4 Film G285 4/24/61 iwk

04138

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Balto. City | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville | | c. LENGTH OF STAY IN 1b
9 yrs. 6 mos. 16 dys. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Springfield State Hospital | | d. STREET ADDRESS
3103 Clearview Ave. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Henry Middle George Last Happ | | 4. DATE OF DEATH
Month April Day 15 Year 19 61 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
November 22, 1896 |
| 9. AGE (In years last birthday)
64 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Odd jobs | | 10b. KIND OF BUSINESS OR INDUSTRY
- | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John H. Happ | | 14. MOTHER'S MAIDEN NAME
Charlotte Walper | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
219-30-8147 | |
| 17. INFORMANT
Springfield Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Old rheumatic heart disease
410X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Emittal stenosis and congestive heart failure
DUE TO (c) heart failure | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Mental Deficiency, idiopathic, moderate. | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from March 7, 1955 to 4-15-61 , that (I) (we) last saw the deceased alive on 4/5 19 61 , and that death occurred at PM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Agustin del Campo M.D. | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
Agustin del Campo, M.D. | | 22d. ADDRESS
Springfield Hospital, Sykesville, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
4/17/61 | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore Cemetery | 23d. LOCATION (City, town, or county) (State)
Baltimore, Maryland |
| 24. FUNERAL DIRECTOR'S SIGNATURE
H. Sander & Sons, Inc., Balto., Md. | | 25a. REC'D BY REGISTRAR
DATE APR 18 '61 | |
| | | 25b. REGISTRAR'S SIGNATURE
Calvin S. Kline | |

CERTIFICATE OF DEATH

MANITOWISH COUNTY, WISCONSIN

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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|--|-------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton | | c. LENGTH OF STAY IN 1b 367 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital | | d. STREET ADDRESS Route 1#, Box 668 | |
| 3. NAME OF DECEASED (Type or print)
First Joseph Middle Oscar Last Harley | | 4. DATE OF DEATH
Month April Day 16 Year 1961 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 9, 1893 |
| 9. AGE (In years last birthday) 67 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Brandywine, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Henry Harley | | 14. MOTHER'S MAIDEN NAME Ella Proctor | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 578-42-3129 | |
| 17. INFORMANT Joseph O. Harley - Patient | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Far advanced bilateral pulmonary tuberculosis
DUE TO with bilateral cavitations
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) with bilateral cavitations
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from April 14, 1961 to April 16, 1961 that (I) (we) last saw the deceased alive on April 16, 1961 and that death occurred at 1:00 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Edgars M. Maculans | | 22b. DATE 4-16-61 | |
| 22c. PHYSICIAN'S NAME (Type) Edgars M. Maculans, M.D. | | 22d. ADDRESS Henryton State Hospital, Henryton, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 4-19-61 | |
| 23c. NAME OF CEMETERY OR CREMATORY St. Joseph's | | 23d. LOCATION (City, town, or county) (State) POMFRET, MD | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Walter F. ... | | 25a. REC'D BY REGISTRAR APR 20 '61 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. ... | | | |

04130

TECHNICAL AIR-01-1474

1110

(M)

1. The purpose of this document is to provide information regarding the technical aspects of the aircraft engine. The document is intended for use by personnel responsible for the maintenance and operation of the aircraft.

2. The document is organized into sections, each dealing with a specific aspect of the engine. The sections are as follows:

3. The first section, "General Information," provides an overview of the engine and its components. It includes a list of the major components and a description of their functions.

4. The second section, "Maintenance Procedures," describes the methods for inspecting, cleaning, and repairing the engine components. It includes a list of the tools and materials required for each procedure.

5. The third section, "Troubleshooting," provides information on how to identify and correct common engine problems. It includes a list of the symptoms and the steps to be taken to resolve each problem.

6. The fourth section, "Safety," provides information on the safety precautions that must be followed when working on the engine. It includes a list of the hazards and the steps to be taken to avoid them.

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

4146

04140

| | | | |
|--|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore City 30 ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville | | c. LENGTH OF STAY IN 1b
13 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Springfield State Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First William Middle Phillip Last Haxel | | 4. DATE OF DEATH
Month 4 Day 9 Year 1961 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2-19-1876 |
| 9. AGE (In years last birthday)
85 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Unknown SALESMAN | | 10b. KIND OF BUSINESS OR INDUSTRY
SWIFT Co. | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Phillip Haxel | | 14. MOTHER'S MAIDEN NAME
Appolnia Swing | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
Unknown | | 16. SOCIAL SECURITY NO.
— | |
| 17. INFORMANT
Hospital records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: Arteriosclerotic Heart Disease.
IMMEDIATE CAUSE (a) 420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)
C.B.S. due to cerebral arteriosclerosis
Cerebral infarction due to arteriosclerosis | | | |
| INTERVAL BETWEEN ONSET AND DEATH
years | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 3-27- 19 61 to 4-9- 19 61 , that (I) (we) last saw the deceased alive on 4-8- 19 61 , and that death occurred at 4:30 M., from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Agustin del Campo M.D. | | 22b. DATE
4-9-1961 | |
| 22c. PHYSICIAN'S NAME (Type)
Agustin del Campo M.D. | | 22d. ADDRESS
Springfield State Hospital, Sykesville, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
APRIL 11, 1961 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Logdon Park Cem. | | 23d. LOCATION (City, town, or county) (State)
BA LTO. MD. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
G. TRUMAN SCHWAB | | 25a. REC'D BY REGISTRAR
DATE APR 11 '61 | |
| ADDRESS
3512 Frederick Ave. | | 25b. REGISTRAR'S SIGNATURE
Charles S. Hume | |

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1. The first part of the report is a general statement of the purpose and scope of the investigation. It is followed by a description of the methods used in the study.

2. The second part of the report is a detailed account of the results of the investigation. It includes a description of the data collected and a discussion of the findings.

3. The third part of the report is a conclusion and a list of references. The conclusion summarizes the main points of the report and the references list the sources of information used in the study.

4. The fourth part of the report is an appendix containing additional information that is not included in the main text of the report.

5. The fifth part of the report is a bibliography listing the sources of information used in the study.

6. The sixth part of the report is a list of figures and tables that are included in the report.

7. The seventh part of the report is a list of abbreviations and symbols used in the report.

8. The eighth part of the report is a list of footnotes that provide additional information about the report.

9. The ninth part of the report is a list of references that are cited in the report.

10. The tenth part of the report is a list of figures and tables that are included in the report.

11. The eleventh part of the report is a list of abbreviations and symbols used in the report.

12. The twelfth part of the report is a list of footnotes that provide additional information about the report.

13. The thirteenth part of the report is a list of references that are cited in the report.

14. The fourteenth part of the report is a list of figures and tables that are included in the report.

15. The fifteenth part of the report is a list of abbreviations and symbols used in the report.

16. The sixteenth part of the report is a list of footnotes that provide additional information about the report.

17. The seventeenth part of the report is a list of references that are cited in the report.

18. The eighteenth part of the report is a list of figures and tables that are included in the report.

19. The nineteenth part of the report is a list of abbreviations and symbols used in the report.

20. The twentieth part of the report is a list of footnotes that provide additional information about the report.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04141

4147

| | | | | | | | |
|--|--|--|---|--|--------------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Carroll</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>59 John St</u> | | | | c. LENGTH OF STAY IN 1b <u>30 yrs</u> | | | |
| d. NAME OF HOSPITAL or (Institution, give street address) OR INSTITUTION <u>Westminster</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>NATHAN OWEN HOLLENBAUGH</u> | | | | 4. DATE OF DEATH Month Day Year <u>April 21 1961</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept 27 1871</u> | 9. AGE (In years last birthday) <u>89</u> yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>blacksmith</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u> | | 11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Immanuel Hollenbaugh</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Catherine Mill</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. <u>Imm</u> | | 17. INFORMANT <u>Mrs Fred Mays, same address</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiovascular Renal Disease</u>
<u>442X</u> DUE TO (b) <u>Hypertension</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Arterio Sclerosis senile</u>
INTERVAL BETWEEN ONSET AND DEATH <u>Several yrs</u>
<u>10 yrs</u>
<u>Several yrs</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan 23 1961</u> to <u>April 21 1961</u> , that (I) (we) last saw the deceased alive on <u>April 19 1961</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>W. Glenn Speicher</u> | | M.D. | ATTENDING PHYS. <input checked="" type="checkbox"/> | MED. DIRECTOR <input type="checkbox"/> | STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>Westminster Md</u> | | 22d. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>4/24/61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Popple Creek Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Rural, Westminster Md.</u> | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myers Jr.</u> | | ADDRESS <u>Westminster Md</u> | 25a. RECEIVED BY REGISTRAR <u>APR 25 '61</u> | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kincaid</u> | | | |

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

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(M)

(2)

CHIEF CLERK

MASSACHUSETTS
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
DIVISION OF BIRTH AND DEATH RECORDS

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4148

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04142

| | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Carroll | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville | | c. LENGTH OF STAY IN 1b
3yrs. 9mos. 9das | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Maryland | | b. COUNTY
Baltimore | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Springfield State Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | d. STREET ADDRESS
5501 Frankford Ave. | | | | | |
| 3. NAME OF DECEASED (Type or print)
First
Otto | | Middle
Huber | | Last
Huber | | 4. DATE OF DEATH
Month
April | | Day
4 | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
5-29-1877 | | 9. AGE (In years last birthday)
83 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Butcher | | 10b. KIND OF BUSINESS OR INDUSTRY
- | | 11. BIRTHPLACE (State or foreign country)
Germany | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
Karl Huber | | 14. MOTHER'S MAIDEN NAME
Katherine - | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
216-05-3105 | | 17. INFORMANT
Springfield Records | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Terminal Bronchopneumonia
DUE TO
(b) senile brain disease, with psychotic reaction.
DUE TO
(c) CBS associated with disturbance of metabolism growth or nutrition, with | | INTERVAL BETWEEN ONSET AND DEATH
days | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | 21. I certify that (I) (this hospital) attended the deceased from 6-25- 1957 , to 4-4- 1961 that (I) (we) last saw the deceased alive on 4-4- 1961 , and that death occurred at 2:30 AM from the causes and on the date stated above. | | 22a. SIGNATURE
Agustin del Campo | | 22b. DATE SIGNED
April 4, 1961 | | 22c. PHYSICIAN'S NAME (Type)
Agustin del Campo, M.D. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
4/6/61 | | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE CEM. | | 23d. LOCATION (City, town, or county) (State)
BALTO., MD. | | 25a. REC'D BY REGISTRAR
APR 6 '61 | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Hatley Miller | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | 25c. ADDRESS
2334 Jefferson St. | | 25d. DATE
APR 6 '61 | | | |

CERTIFICATE OF DEATH

1912

(M)

(1)

Blank form with horizontal lines for text entry.

Signature

Date

Time

Place

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained in the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
4149
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
04143

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY CARROLL MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY CARROLL | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
UNION MILLS | | c. LENGTH OF STAY IN 1b
27 WESTMINSTER | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
MEADOW VIEW CONVALESCENT HOME | | d. STREET ADDRESS
118 CARROLL ST | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
BESSIE MARY LYDIA HULL | | 4. DATE OF DEATH Month Day Year
APRIL 4 1961 | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept. 25, 1879 |
| 9. AGE (In years last birthday) yrs.
81 | | 10. IF UNDER 1 YEAR Months Days Hours Min.
2 yrs 4 yrs | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
— | |
| 11. BIRTHPLACE (State or foreign country)
Fredrick Co. Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Cornelius R. Den | | 14. MOTHER'S MAIDEN NAME
Mary R. Metzger | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
— | | 16. SOCIAL SECURITY NO.
— | |
| 17. INFORMANT
Arthur R. Hull, same address | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) arteriosclerotic heart disease
420.9 (c) + cerebral softening
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis
DUE TO (c) arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH
2 yrs 4 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Fracture of thigh Jan 23, 1961 | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan 9, 1961 to Apr 4, 1961 , that (I) (we) lost the deceased on 4-4-1961 , and that death occurred at 9:57 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
a Reuselbens | | 22b. DATE SIGNED
Apr 5, 1961 | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. E. REESE Wilkins | | 22d. ADDRESS
15 Kenner Westminister, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4/7/61 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Cragers Storm Cemetery | | 23d. LOCATION (City, town, or county) (State)
Cragers Storm Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
J. E. Myers, Jr. Westminister, Md. | | 25a. REC'D BY REGISTRAR
DATE APR 10 '61 | |
| | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Evans | |

1

4150

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04144

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Frederick | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN 1b 1 mo. - 20 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | d. STREET ADDRESS - | | | |
| 3. NAME OF DECEASED (Type or print)
First Amos Middle Remsberg Last Keller | | | | 4. DATE OF DEATH
Month 4 Day 29 Year 1961 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH December 3, 1884 | |
| 9. AGE (In years last birthday) 76 yrs. | | IF UNDER 1 YEAR
Months 4 Days 29 Hours 10 Min. 0 | | IF UNDER 24 HRS.
Months 4 Days 29 Hours 10 Min. 0 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Farming | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 13. FATHER'S NAME Charles Keller | | | |
| 14. MOTHER'S MAIDEN NAME - Annie Remsberg | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | |
| 16. SOCIAL SECURITY NO. - | | | | 17. INFORMANT Springfield Hospital Records Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction. DUE TO 420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary occlusion. DUE TO 2 weeks
(c) Arteriosclerotic heart disease. DUE TO 2 weeks
years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease with psychotic reaction. | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 2 weeks | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from March 9, 1961 to April 29, 1961 , that (I) (we) last saw the deceased alive on April 29, 1961 , and that death occurred at 10:30 p.m. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Agustin del Campo | | | | 22b. DATE SIGNED 4-29-61 | | | |
| 22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. | | | | 22d. ADDRESS Springfield Hospital, Sykesville, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | | | | 23b. DATE THEREOF 5/2/1961 | | | |
| 23c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery | | | | 23d. LOCATION (City, town, or county) (State) Middletown, Md. | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, | | | | 25a. REC'D BY REGISTRAR MAY 3 '61 | | | |
| ADDRESS Middletown, Md. | | | | 25b. REGISTRAR'S SIGNATURE Arthur L. Kiser | | | |

MEDICAL CERTIFICATION

M

11:50

CERTIFICATE OF DEATH

11:15

Blank lined area for text entry, containing faint mirrored text from the reverse side of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Balto. City | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville | | c. LENGTH OF STAY IN 1b
lyr. 1mo., 2 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
Springfield State Hospital | | d. STREET ADDRESS
3711 Belair Road | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Clarence Middle Warnock Last Kennedy | | 4. DATE OF DEATH
Month April Day 25 Year 19 61 | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
1891 | |
| 9. AGE (In years lost birthday) 70 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Carpenter | | 10b. KIND OF BUSINESS OR INDUSTRY
- | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
J. Henry Kennedy | | 14. MOTHER'S MAIDEN NAME
Mary Gill | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
- | |
| 17. INFORMANT
Springfield Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
420.0 IMMEDIATE CAUSE (a) Acute coronary insufficiency
DUE TO Arteriosclerotic heart disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
C.B.S. associated with cerebral arteriosclerosis, with psychotic reaction. | | | |
| INTERVAL BETWEEN ONSET AND DEATH
Minutes
Years | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | |
| 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from March 23, 19 60 to April 25, 19 61 that (I) (we) last saw the deceased alive on April 25, 19 61 and that death occurred at 10 AM from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Agustin del Campo, M.D. | | | |
| 22b. DATE SIGNED
4/25/61 | | | |
| 22c. PHYSICIAN'S NAME (Type)
Agustin del Campo, M.D. | | | |
| 22d. ADDRESS
Springfield Hospital, Sykesville, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | |
| 23b. DATE THEREOF
April 28, 61 | | | |
| 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | | |
| 23d. LOCATION (City, town, or county) (State)
Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Leonard J. Buck, Inc. 5305 Harford Rd., Balto. Md. | | | |
| 25a. REC'D BY REGISTRAR
DATE APR 27 '61 | | | |
| 25b. REGISTRAR'S SIGNATURE
William S. Kraus | | | |

1991

24

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4152

04146

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Carroll
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Springfield State Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Joseph Middle Kujawa Last Kujawa | | 4. DATE OF DEATH
Month 4 Day 8 Year 1961 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1-5-96 |
| 9. AGE (In years last birthday)
65 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Watchman | | 10b. KIND OF BUSINESS OR INDUSTRY
- | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Frank Kujawa | | 14. MOTHER'S MAIDEN NAME
Josephine Bednarska | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
119-12-8418 | |
| 17. INFORMANT
Springfield Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CA of lung.
163 X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | INTERVAL BETWEEN ONSET AND DEATH
months |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 2/22/61 19____, to 4/8/61 19____, that (I) (we) last saw the deceased alive on 4/8/61 19____, and that death occurred at 5P. M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Agustin del Campo
M.D. | | 22b. DATE SIGNED
4/8/61 | |
| 22c. PHYSICIAN'S NAME (Type)
Agustin del Campo, M.D. | | 22d. ADDRESS
Springfield Hospital, Sykesville, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
4-12-1961 | 23c. NAME OF CEMETERY OR CREMATORY
St. Stanislaus | 23d. LOCATION (City, town, or county) (State)
Dundalk Ave. Md. |
| 24. FUNERAL DIRECTOR'S SIGNATURE
JOHN J. DUDA 2829 Hudson St. 24, Md. | | 25. REC'D BY REGISTRAR
DATE APR 13 '61 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur L. Kraus | | | |

MEDICAL CERTIFICATION

BP

CERTIFICATE OF DEATH

413

1

1

4153

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04147

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Balto. City | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville | | c. LENGTH OF STAY IN 1b
1yr. 3mos. 20days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Springfield State Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Edith Annie Middle Foster Last Lopez | | 4. DATE OF DEATH
Month April Day 19 Year 1961 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 6, 1890 |
| 9. AGE (In years last birthday)
70 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
- | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Joseph Foster | | 14. MOTHER'S MAIDEN NAME
Annie Warner | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
- | |
| 17. INFORMANT
Springfield Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Recurrent cardiovascular accident
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hypertensive arteriosclerotic cardiovascular disease
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Diabetes Mellitus. Involutional psychotic reaction. | | | |
| INTERVAL BETWEEN ONSET AND DEATH
Days
Years. | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from December 29, 1959 to April 19, 1961 , that (I) (we) last saw the deceased alive on April 19, 1961 , and that death occurred at 11:20 AM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Agustin del Campo | | 22b. DATE
4/19/61 | |
| 22c. PHYSICIAN'S NAME (Type)
Agustin del Campo, M.D. | | 22d. ADDRESS
Springfield Hospital, Sykesville, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
REMOVAL | | 23b. DATE THEREOF
4-21-61 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Wright Anatomy Room at | | 23d. LOCATION (City, town, or county) (State)
Baltimore, Md | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
James H. Newell | | 25. REC'D BY REGISTRAR
24 '61 | |
| ADDRESS
Rt 200 | | 25b. REGISTRAR'S SIGNATURE
Charles E. Thomas | |

1123

(M)

(1)



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

M

I

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 4154 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Carroll</u> | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Union Bridge Rd #1</u> | | | | | | c. LENGTH OF STAY IN 1b
<u>64 years</u> | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>near Banast Church</u> | | | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Union Bridge Rd #1</u> | | | | | |
| f. STREET ADDRESS
<u>near Banast Church</u> | | | | | | g. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>GEORGE</u> Middle <u>WILLIAM</u> Last <u>MARQUET</u> | | | | | | 4. DATE OF DEATH
Month <u>Apr</u> Day <u>20</u> Year <u>19 61</u> | | | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>June 12 1896</u> | | 9. AGE (In years last birthday)
<u>64 yrs.</u> | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>self employed</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Carroll Co. Md</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A</u> | | | | | |
| 13. FATHER'S NAME
<u>Charles Marquet</u> | | | | | | 14. MOTHER'S MAIDEN NAME
<u>Flora Lambert</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> | | | | | | 16. SOCIAL SECURITY NO.
<u>217-36-4861</u> | | | | | |
| 17. INFORMANT
<u>Mrs Hilda C. Marquet</u> | | | | | | Address
<u>same address</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Crushing injury to chest</u>
912.1 } DUE TO
Conditions, if any, which }
gave rise to immediate cause }
(a), stating the underlying }
cause last, }
(b) <u>farm tractor upset</u>
(c) <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
<u>farm tractor upset.</u> | | | | | |
| 20c. TIME OF INJURY
Hour <u>12:15</u> p.m. Month, Day, Year <u>4/20/19 61</u> | | 20d. INJURY OCCURRED
While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>Farm</u> | | 20f. (City or town)
<u>Union Bridge</u> | | (County)
<u>Carroll</u> | | (State)
<u>Md</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE
<u>James T. Marsh</u> | | | | | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| EXAMINER'S NAME (Type)
<u>JAMES T MARSH</u> | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| Address (Street, city, town, or county)
<u>Westminster Md</u> | | | | | | DATE SIGNED
<u>4/20/61</u> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>4/23/61</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Kraders Cemetery</u> | | 22d. LOCATION (City, town, or country)
<u>near Westminster Md</u> | | (State)
<u>Md</u> | | | |
| 23. FUNERAL DIRECTOR
<u>J. E. Myers, Jr.</u> | | | | | | 24a. REC'D BY REGISTRAR
<u>Westminster, Md</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kraus</u> | | DATE
<u>APR 25 '61</u> | |

10-150

UNITED STATES DEPARTMENT OF HEALTH
MEDICAL RESEARCH SERVICE
OFFICE OF THE ASSISTANT SECRETARY
FOR MEDICAL RESEARCH
WASHINGTON, D. C. 20492

1114

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

4155

04149

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Queen Anne's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville | | | | c. LENGTH OF STAY IN 1b
32yrs.7mos.13 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Springfield State Hospital | | | | d. STREET ADDRESS
- | | | |
| 3. NAME OF DECEASED (Type or print)
First Clara Middle McDaniel Last McDaniel | | | | 4. DATE OF DEATH
Month April Day 20 , Year 19 61 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
1887 | |
| 9. AGE (In years lost birthday)
74 yrs. | | IF UNDER 1 YEAR
Months 74 Days 74 Hours 74 Min. | | IF UNDER 24 HRS.
Months 74 Days 74 Hours 74 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | | | 10b. KIND OF BUSINESS OR INDUSTRY
- | | 11. BIRTHPLACE (State or foreign country)
Delaware | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
Unknown | | | | 14. MOTHER'S MAIDEN NAME
Jane Ward | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
- | | 17. INFORMANT
Springfield Hospital Records | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Renal failure
DUE TO
(c) Arteriosclerotic heart disease | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH
Days
Weeks
Years | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epilepsy with mental deficiency. | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | | | | |
| 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | | | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | | | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from March 7, 19 66 to April 20, 19 61 that (I) (we) lost the deceased alive on April 19, 19 61 , and that death occurred at 4:45 AM from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Agustin del Campo M.D. | | | | | | | |
| 22b. DATE SIGNED
4/20/61 | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type)
Agustin del Campo, M.D. | | | | | | | |
| 22d. ADDRESS
Springfield Hospital, Sykesville, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
4-25-61 | | | | | | | |
| 23b. DATE THEREOF
4-25-61 | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY
Wm Ananias | | | | | | | |
| 23d. LOCATION (City, town, or county) (State)
Baltimore, Md. | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Frank H Newell ADDRESS
Pikes 18 m of | | | | | | | |
| 25a. REC'D BY REGISTRAR
APR 26 '61 | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE
Charles S. Hume | | | | | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

4156

04150

| | | | | | | | | |
|---|----------------------------------|---|---|--|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Frederick | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville | | | | c. LENGTH OF STAY IN 1b
2yrs. 9months, 17days | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Springfield State Hospital | | | | d. STREET ADDRESS
- | | | | |
| 3. NAME OF DECEASED (Type or print)
First Robert Middle Patrick Last McKenzie | | | | 4. DATE OF DEATH
Month April Day 6 Year 19 61 | | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
March 15, 1898 | | 9. AGE (In years last birthday)
63 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Factory worker | | 10b. KIND OF BUSINESS OR INDUSTRY
- | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
James McKenzie | | | | 14. MOTHER'S MAIDEN NAME
Rebecca Bolden | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
217-10-1236 | | 17. INFORMANT Address
Springfield Hospital Records | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart failure
434.4 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertrophy of right ventricle
DUE TO (c) Bronchopneumonia | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Weeks
Months
Days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Manic depressive reaction, manic type. Healed pulmonary tuberculosis. | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from June 19, 1958 to April 6, 1961 , that (I) (we) last saw the deceased alive on April 6, 1961 , and that death occurred at 6:55 PM from the causes and on the date stated above. | | | | | | | | |
| 22a. SIGNATURE
<i>Agustin del Campo</i> | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
4/6/61 | | |
| 22c. PHYSICIAN'S NAME (Type)
Agustin del Campo, M.D. | | | | 22d. ADDRESS
Springfield Hospital, Sykesville, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4/10/61 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Marys | | 23d. LOCATION (City, town, or county) (State)
Barnesville Md. | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<i>Constance C. Hilton</i> | | | | ADDRESS
<i>Barnesville Md.</i> | | 25a. REC'D BY REGISTRAR
DATE APR 11 1961 | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<i>Arthur L. Hines</i> | | | | |

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CERTIFICATE OF DEATH

04150

MD.

Baltimore

St. Marys

1901

March

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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ISM 9/59

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04151

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|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Carroll | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Maryland | | b. COUNTY
Balto. City | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville | | c. LENGTH OF STAY IN 1b
3mos. 2days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 18 | | 3V01-4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Springfield State Hospital | | | | d. STREET ADDRESS
510 Rose Hill Terrace | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) | | First
Carrie | | Middle
Adele | | Last
Miller | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF DEATH
Month
April | |
| | | | | | | Day
10, | |
| | | | | | | Year
1961 | |
| 9. AGE (In years lost birthday)
84 | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
- | | 10c. BIRTHPLACE (State or foreign country)
Maryland | |
| | | | | | | 10d. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John Miller | | | | 14. MOTHER'S MAIDEN NAME
Margaret E. Wilson | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
- | | 17. INFORMANT
Springfield Hospital Records | | | |
| | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
491X IMMEDIATE CAUSE (a) Bronchopneumonia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease with psychotic reaction. | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Days | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour a. m. _____
p. m. _____
19 | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that (I) (this hospital) attended the deceased from January 8, 1961 to April 10, 1961 , that (I) (we) lost saw the deceased alive on April 9, 1961 , and that death occurred at 3:30AM from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Agustin del Campo | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
4/10/61 | |
| 22c. PHYSICIAN'S NAME (Type)
Agustin del Campo, M.D. | | | | 22d. ADDRESS
Springfield Hospital, Sykesville, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
April 12, 1961 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cent. | | 23d. LOCATION (City, town, or county) _____ (State) _____
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
John A. Moran | | | | 25a. REC'D BY REGISTRAR
DATE APR 12 '61 | | 25b. REGISTRAR'S SIGNATURE
Arthur J. Evans | |

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1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

4158

04152

| | | | |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Balto. City ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | c. LENGTH OF STAY IN 1b 32yrs. 6mos. 27days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | d. STREET ADDRESS 3115 E. Baltimore St. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Eugene Middle Mincher Last | | 4. DATE OF DEATH
Month April Day 23 Year 19 61 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 4, 1882 |
| 9. AGE (In years last birthday) 78 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Unknown | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William B. Mincher | | 14. MOTHER'S MAIDEN NAME Mary J. Mincher | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. - | |
| 17. INFORMANT Springfield Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Terminal bronchopneumonia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 491X
DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH Days. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Epilepsy with mental deficiency. - Generalized arteriosclerosis. | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from March 7, 1955 to April 23, 1961 that (I) (we) last saw the deceased alive on April 22, 1961 and that death occurred at 6:50AM from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Agustin del Campo M.D. | | 22b. DATE SIGNED 4/23/61 | |
| 22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. | | 22d. ADDRESS Springfield Hospital, Sykesville, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 4-26-61 | |
| 23c. NAME OF CEMETERY OR CREMATORY New Cathedral | | 23d. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Arthur H. Haight ADDRESS Sykesville, Md. | | 25a. REC'D BY REGISTRAR DATE APR 28 '61 | |
| | | 25b. REGISTRAR'S SIGNATURE Arthur H. Haight | |

04173

CERTIFICATE OF DEATH

4132



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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4159

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04153

| | | | |
|---|-------------------------------|--|----------------------------------|
| 1. PLACE OF DEATH
o. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | c. LENGTH OF STAY IN 1b 43yr. 9mos. 17das. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | d. STREET ADDRESS - Unknown | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First William Middle T. Last Minnis | | 4. DATE OF DEATH Month April Day 13 Year 1961 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-24-82 |
| 9. AGE (In years last birthday) 78 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Draftsman | | 10b. KIND OF BUSINESS OR INDUSTRY Unknown | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Minnis | | 14. MOTHER'S MAIDEN NAME Sarah Harrison | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. - | |
| 17. INFORMANT Springfield Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bilateral lobular pneumonia with multiple abscesses DUE TO 490X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, catatonic type
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 6-26-1917 , to 4-13-1961 , that (I) (we) last saw the deceased alive on 4-13-1961 , and that death occurred at 6:45 PM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Agustini del Campo. M.D. | | 22b. DATE SIGNED April 13, 1961 | |
| 22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. | | 22d. ADDRESS Springfield Hospital, Sykesville, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 4-21-61 | |
| 23c. NAME OF CEMETERY OR CREMATORY New Cathedral | | 23d. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Ruth H. Haight Address Sykesville, Md. | | 25a. REC'D BY REGISTRAR DATE APR 24 '61 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | |

CERTIFICATE OF DEATH

1915

(M)

NAME _____
AGE _____
SEX _____
DATE OF BIRTH _____
PLACE OF BIRTH _____
OCCUPATION _____
CAUSE OF DEATH _____
DATE OF DEATH _____
PLACE OF DEATH _____
SIGNATURE _____
OFFICIAL _____

(I)

(S)

(S)

(S)

(S)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

4160

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04154

| | | | |
|--|-------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Carnall</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Carnall</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> | | c. LENGTH OF STAY IN 1b <u>50 yrs</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> | | 27 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Davis Apts - S. Main St</u> | | d. STREET ADDRESS <u>Davis Apts - S. Main St 1</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>RUTHANNA</u> Middle <u>MOORE</u> Last <u>MOORE</u> | | 4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>1961</u> | |
| 5. SEX <u>female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov-22 1895</u> |
| 9. AGE (In years lost birthday) <u>65</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>6</u> Days <u>5</u> Hours <u>15</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>bookkeeper - Furniture Store</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Carroll Co. Md</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Howard Wantz</u> | | 14. MOTHER'S MAIDEN NAME <u>Archie Rinehart</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>Edgar G. Rhode, Reston, Md</u> | |
| 17. INFORMANT Address <u>Edgar G. Rhode, Reston, Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u>
153.2 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of descending Colon</u> DUE TO
(c) <u>3 yrs</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>10 mos</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1, 1950</u> to <u>April 23, 1961</u> , that (I) (we) last saw the deceased alive on <u>Apr 23, 1961</u> , and that death occurred <u>9:45 P</u> M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Julius Chopko</u> | | 22b. DATE SIGNED <u>4/24/61</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Julius Chopko</u> | | 22d. ADDRESS <u>85 E W. Green, Westminster Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>4/27/61</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Meadow Branch</u> | | 23d. LOCATION (City, town, or county) (State) <u>Rural, Westminster Md</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myers Jr.</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u> | |
| ADDRESS <u>Westminster Md</u> | | 25a. REC'D BY REGISTRAR DATE <u>APR 28 '61</u> | |

00150

CENTRAL BANK OF AMERICA

0180

(M)

(T)

Western Union
Telegraph Company

Oct 1 1907

James C. [unclear]
[unclear] Chicago

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

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4161
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04155

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
c. LENGTH OF STAY IN 1b 12yrs. 3mths, 22days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital. | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore County
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
d. STREET ADDRESS 1615 Dartford Road
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) Clara Nager
First Middle Last
4. DATE OF DEATH
Month 4 Day 20 Year 1961 | | 5. SEX Female
6. COLOR OR RACE White
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH 10-8-1910
9. AGE (In years lost birthday) 50 yrs.
IF UNDER 1 YEAR: Months 50 Days 50 Hours 50 Min. 50 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office work
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Rumania
12. CITIZEN OF WHAT COUNTRY? Unknown | | 13. FATHER'S NAME Benjamin Fisher (Dec)
14. MOTHER'S MAIDEN NAME Pauline Aronowitz (Dec) | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no
16. SOCIAL SECURITY NO. UNKNOWN
17. INFORMANT Hospital records
Address | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
420.0 DUE TO Arteriosclerotic Heart Disease.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) —
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenic reaction, paranoid type.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19
20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | | 21. I certify that (I) (this hospital) attended the deceased from March 7 1955 to April 20 1961 , that (I) (we) last saw the deceased alive on April 20 1961 and that death occurred at 6:50 P.M. from the causes and on the date stated above. | |
| 22a. SIGNATURE Agustin del Campo
22b. PHYSICIAN'S NAME (Type) Agustin del Campo M.D.
22c. DATE 4-20-1961
22d. ADDRESS Springfield State Hospital Sykesville, Md. | | 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 4/23/1961
23c. NAME OF CEMETERY OR CREMATORY Beth Shalom Cem.
23d. LOCATION (City, town, or county) (State) Cap. Hts., Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Deborah Funeral Home 4217-9th St
ADDRESS 4217-9th St | | 25a. REC'D BY REGISTRAR APR 24 '61
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

04350

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

4162

04156

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|---|--|---|--|--|--|--|----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Henryton | | | | c. LENGTH OF STAY IN 1b
1 day | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Annapolis | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Henryton State Hospital | | | | d. STREET ADDRESS
52 Shaw Street | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Beatrice Middle Peal Last Peal | | | | 4. DATE OF DEATH
Month April Day 13 Year 1961 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
2-12-10 | |
| 9. AGE (In years lost birthday)
51 yrs. | | IF UNDER 1 YEAR
Months 51 Days 51 Hours 51 Min. | | IF UNDER 24 HRS.
Months 51 Days 51 Hours 51 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | | | 10b. KIND OF BUSINESS OR INDUSTRY
A. A. Co., Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Joseph Peal | | | | 14. MOTHER'S MAIDEN NAME
Louise Brown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
unknown | | 17. INFORMANT
Beatrice Peal - Patient Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Far Advanced Bilateral Pulm. Tbc.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Cardiovascular Insufficiency
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 4-13 1961 to 4-13 1961 , that (I) (we) last saw the deceased alive on 4-13 1961 , and that death occurred at 11:50 a.m. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<i>Edgars M. Maculans</i> | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
4-13-61 | |
| 22c. PHYSICIAN'S NAME (Type)
Edgars M. Maculans | | | | 22d. ADDRESS
Henryton State Hospital | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4-15-61 | | 23c. NAME OF CEMETERY OR CREMATORY
Brewer Hill | | 23d. LOCATION (City, town, or county) (State)
Annapolis, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<i>William Reese, Jr. - Annapolis, Md.</i> | | | | 25a. REC'D BY REGISTRAR
DATE APR 14 '61 | | 25b. REGISTRAR'S SIGNATURE
<i>Arthur S. Kraus</i> | |

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MEDICAL CERTIFICATION

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1152

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "General", "Housing", and "State" are partially visible.]

Special Agent in Charge
 Federal Bureau of Investigation
 Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4163

Item 1c Film G286

5/31/61 iwk

04157

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH
o. COUNTY
Carroll
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE
Maryland
b. COUNTY
Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville | | c. LENGTH OF STAY IN 1b
3 yrs. 11 days | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring | | 15 25-2 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Springfield State Hospital | | d. STREET ADDRESS
8722 Cameron St. | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Elsie Mamie Warfield Purdum | | 4. DATE OF DEATH
Month Day Year
April 21 19 61 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
April 8, 1888 |
| 9. AGE (In years last birthday)
73 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Practical Nurse | | 10b. KIND OF BUSINESS OR INDUSTRY
- | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Pradby Warfield | | 14. MOTHER'S MAIDEN NAME
Mary Browning | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No - | | 16. SOCIAL SECURITY NO.
- | |
| 17. INFORMANT
Springfield Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Pyelonephritis and renal calculus
DUE TO
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Psychotic depressive reaction. | | | |
| INTERVAL BETWEEN ONSET AND DEATH
Weeks
Months | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from April 10, 1958 to 4 - 21 , 19 61 , that (I) (we) last saw the deceased alive on 4 - 21 , 19 61 , and that death occurred at 11 P M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Agustin del Campo
M.D. | | 22b. DATE SIGNED
APR 25 '61 | |
| 22c. PHYSICIAN'S NAME (Type)
Agustin del Campo, M.D. | | 22d. ADDRESS
Springfield Hospital, Sykesville, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4/25/61 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Providence Meth. | | 23d. LOCATION (City, town, or county) (State)
Kemptown, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Olin L. Mounther
ADDRESS
Damascus, Md. | | 25a. REC'D BY REGISTRAR
DATE
APR 25 '61 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur L. Kline | | | |

49



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **04158**

4164

| | | | | | | | |
|---|----------------------------------|---|---|---|---|--|--|
| 1. PLACE OF DEATH
o. COUNTY <i>Carroll</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admision)
o. STATE <i>md</i> b. COUNTY <i>Carroll</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Rural Manchester</i> | | c. LENGTH OF STAY IN 1b
<i>77 yrs</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Rural Manchester</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<i>Manchester P.O. #1</i> | | | | e. STREET ADDRESS
<i>Manchester md RD #1</i> | | f. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <i>SUSIE</i> Middle <i>MILLER</i> Last <i>RESSER</i> | | | | 4. DATE OF DEATH
Month <i>April</i> Day <i>6</i> Year <i>1961</i> | | | |
| 5. SEX
<i>Female white</i> | 6. COLOR OR RACE
<i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>Sept 26 1871</i> | 9. AGE (In years last birthday)
<i>89</i> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY
<i>md.</i> | | 11. BIRTHPLACE (State or foreign country)
<i>md.</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | |
| 13. FATHER'S NAME
<i>Opel Miller</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>Sydia Switzer</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<i>no</i> | | 16. SOCIAL SECURITY NO.
<i>None</i> | | 17. INFORMANT
<i>Sydia Switzer</i> Address <i>Manchester, md. #1</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cornary Occlusion</i>
<i>420.1</i> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cornary Sclerosis</i>
DUE TO (c) <i>Hypertensive Arteriosclerotic Cardio-vascular Dis.</i>
<i>20 yrs.</i> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Renal Insufficiency</i> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)
<input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>Nov. 26</i> , 19 <i>60</i> , to <i>April 6</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>April 6</i> , 19 <i>61</i> , and that death occurred at <i>2:45 P.M.</i> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <i>Stuart K. Remley</i> M.D. | | | | DATE SIGNED <i>Glen Rock, Penna. 4/7/61</i> | | | |
| PHYSICIAN'S NAME (Type) <i>Stuart K. Remley, M.D.</i> | | | | ADDRESS <i>Glen Rock, Penna.</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 22b. DATE THEREOF
<i>4/8/61</i> | | 22c. NAME OF CEMETERY OR CREMATORY
<i>Black Rock Church</i> | | 22d. LOCATION (City, town, or county) (State)
<i>London md RD</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>W. G. ...</i> | | | | 24a. REC'D BY REGISTRAR
DATE <i>APR 10 '61</i> | | 24b. REGISTRAR'S SIGNATURE
<i>Arthur S. ...</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11-158

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| <p>1. NAME OF DECEASED
<i>John Doe</i></p> | | <p>2. SEX
<i>Male</i></p> | | <p>3. AGE
<i>45</i></p> | | <p>4. RACE
<i>White</i></p> | |
| <p>5. DATE OF DEATH
<i>Nov 15 1918</i></p> | | <p>6. TIME OF DEATH
<i>10:00 AM</i></p> | | <p>7. PLACE OF DEATH
<i>Home</i></p> | | <p>8. CITY
<i>Baltimore</i></p> | |
| <p>9. COUNTY
<i>Harford</i></p> | | <p>10. STATE
<i>Md.</i></p> | | <p>11. MARITAL STATUS
<i>Married</i></p> | | <p>12. OCCUPATION
<i>Farmer</i></p> | |
| <p>13. CAUSE OF DEATH
<i>Heart Disease</i></p> | | <p>14. DISEASE OR INJURY
<i>Myocardial Infarction</i></p> | | <p>15. MODE OF DEATH
<i>Natural</i></p> | | <p>16. PLACE OF BURIAL
<i>St. Mary's Cemetery</i></p> | |
| <p>17. SIGNATURE OF PHYSICIAN
<i>Dr. J. H. Smith</i></p> | | <p>18. SIGNATURE OF REGISTRAR
<i>John Doe</i></p> | | <p>19. SIGNATURE OF WITNESSES
<i>John Doe, Jane Doe</i></p> | | <p>20. SIGNATURE OF DECEASED
<i>John Doe</i></p> | |

1. This certificate is to be filled out by the physician or other person who has attended the deceased.

2. The cause of death should be stated in full, and the mode of death should be stated.

3. The place of death should be stated.

4. The place of burial should be stated.

5. The signature of the physician or other person who has attended the deceased should be written in the space provided.

6. The signature of the registrar should be written in the space provided.

7. The signature of the witnesses should be written in the space provided.

8. The signature of the deceased should be written in the space provided.

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

4165

04159

| | | | |
|---|---------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Cumell</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission)
b. COUNTY <u>Cumell</u> MARYLAND | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Patapsco Rural</u> | | c. LENGTH OF STAY IN 1b
<u>30 yrs</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS
<u>Patapsco - Rural</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>GEORGE - L - SCHOLLIAN</u> | | 4. DATE OF DEATH
Month <u>April</u> Day <u>14</u> Year <u>1961</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>June 16 - 1894</u> |
| 9. AGE (In years last birthday)
<u>66</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Sheet Metal Worker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Md</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Md</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>John H Schollian</u> | | 14. MOTHER'S MAIDEN NAME
<u>Catherine Hoover</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>214-14-5237</u> | |
| 17. INFORMANT
<u>Mrs Geo Schollian - Patapsco Md</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hemorrhage Oesophageal Varices</u>
DUE TO (b) <u>Chronice Arteriosclerotic Myocarditis</u>
DUE TO (c) <u>4221</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH
<u>45 min.</u>
<u>6 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. <u>19</u>
p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June 1955</u> to <u>April 14, 1961</u> that (I) (we) last saw the deceased alive on <u>April 12, 1961</u> and that death occurred at <u>7:50 PM</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>M.C. Porterfield</u> | | 22b. DATE SIGNED
<u>4-15-61</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>M.C. Porterfield, M.D.</u> | | 22d. ADDRESS
<u>Hampstead, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>Apr 17/61</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Baltimore</u> | | 23d. LOCATION (City, town, or county) (State)
<u>Balto Md</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>Edwin H. Hinton</u> | | 25a. REC'D BY REGISTRAR
DATE <u>APR 17 '61</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kraus</u> | | | |

01159

TELETYPE UNIT

01162

(M)

TO DIRECTOR
FROM SAC, NEW YORK
SUBJECT: [Illegible]
[Illegible text follows, appearing to be a teletype message body with several lines of text and possibly a signature block at the bottom.]

04160

| | | | |
|--|-------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Carroll</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Inksterburg RD#1</u> | | c. LENGTH OF STAY IN 1b <u>84 yrs.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sandyment</u> | | d. STREET ADDRESS <u>1 Sandyment</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
<u>ULYSSES HAYES SHIPLEY</u> | | 4. DATE OF DEATH Month Day Year
<u>April 3 1961</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>OCT 19 1876</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u> | 11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md</u> |
| 13. FATHER'S NAME <u>George Shipley</u> | | 14. MOTHER'S MAIDEN NAME <u>Martha Shipley</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>Mr Bertha Bush Shipley</u> | | Address <u>same address</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia (Prob Virus)</u>
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic myocarditis & Volvulus</u>
DUE TO <u>myocarditis</u>
(c) <u>Arterio Sclerosis Genl</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Transurethral Prostatic Resection 2/2/61</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan 25 1961</u> , to <u>April 3 1961</u> , that (I) (we) last saw the deceased alive on <u>April 3 1961</u> , and that death occurred at <u>7:15 PM</u> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>W. Glenn Speicher</u> M.D. | | 22b. DATE SIGNED <u>4/4/61</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Westminster Md</u> | | 22d. ADDRESS <u>Westminster Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>4/6/61</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery Westminster, Md</u> | | 23d. LOCATION (City, town, or county) (State) | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Smyer, Jr.</u> | | 25a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u> | |
| ADDRESS <u>Westminster, Md</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |
| DATE <u>APR 6 '61</u> | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

M

015

I

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY | | Carroll | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE | | Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | Sykesville | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | Westminster | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | Springfield State Hospital | | d. STREET ADDRESS | | 124 E. Green St. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) | | Charles | | Elliot | | Smith, Jr. | | 4. DATE OF DEATH
April 23, 1961 | |
| 5. SEX | | Male | | 6. COLOR OR RACE | | White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH | | February 21, 1930 | | 9. AGE (In years last birthday) | | 31 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | None | | 10b. KIND OF BUSINESS OR INDUSTRY | | - | | 11. BIRTHPLACE (State or foreign country) | |
| 12. CITIZEN OF WHAT COUNTRY? | | U.S.A. | | 13. FATHER'S NAME | | Charles Elliot Smith, Sr. | | 14. MOTHER'S MAIDEN NAME | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | No | | 16. SOCIAL SECURITY NO. | | - | | 17. INFORMANT
Springfield Hospital Records | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 3533
DUE TO Status Convulsivus
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO Epilepsy associated with birth injury
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
C.B.S. assoc. with convulsive disorder with psychotic reaction. | | INTERVAL BETWEEN ONSET AND DEATH
Minutes
?
Life | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town)
(County)
(State) | | 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | |
| 21. ACTUAL SIGNATURE
EXAMINER'S NAME (Type) | | James T. Marsh, M.D. | | 22. CHIEF MEDICAL EXAMINER
ASSISTANT MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER | | DATE SIGNED
4/23/61 | | 23. FUNERAL DIRECTOR
James G. Saffell, Jr. Westminster, Md. | |
| 24a. REC'D BY REGISTRAR
DATE | | APR 26 '61 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kiana | | 25a. BURIAL CREMATION, REMOVAL (Specify)
BURIAL | | 25b. DATE THEREOF
4/25/61 | |
| 25c. NAME OF CEMETERY OR CREMATORY | | St. John's Catholic | | 25d. LOCATION (City, town, or country)
(State) | | Westminster, Md. | | 26. REGISTRAR'S SIGNATURE | |

(3)

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04162

4168

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY
Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Henryton
c. LENGTH OF STAY IN 1b
770 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Henryton State Hospital | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Madison
d. STREET ADDRESS
09X-2
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
John William Stanley | | 4. DATE OF DEATH
Month Day Year
April 1 1961 | |
| 5. SEX
Male | 6. COLOR OR RACE
Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7-5-1888 |
| 9. AGE (In years last birthday)
72 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | 11. IF UNDER 24 HRS.
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY
Farming | |
| 11. BIRTHPLACE (State or foreign country)
Dorchester County Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Solomon Stanley | | 14. MOTHER'S MAIDEN NAME
Maria Jane | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
220-05-0203 | |
| 17. INFORMANT
Rosie Payne | | Address
Box 41, Church Creek, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebro-vascular accident
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last.
(b) Syphilis, arteriosclerosis
DUE TO
(c) Far Advanced Bilateral Pulm. Tbc. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 2-21 5:00 a.m. 4-1 1961 , that (I) (we) last saw the deceased alive on 4-1 1961 , and that death occurred at M , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>Edgars M. Maculans</i> | | 22b. DATE SIGNED
4-1-61 | |
| 22c. PHYSICIAN'S NAME (Type)
Edgars M. Maculans | | 22d. ADDRESS
Henryton State Hospital, Henryton, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Rem-Burial | 23b. DATE THEREOF
4/6/1961 | 23c. NAME OF CEMETERY OR CREMATORY
Madison Cemetery | 23d. LOCATION (City, town, or county) (State)
Madison, Dor. Co., Maryland |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<i>Richard M. Williams Jr.</i> | | 25a. REC'D BY REGISTRAR
DATE APR 10 '61 | |
| ADDRESS
Cambridge, Md | | 25b. REGISTRAR'S SIGNATURE
<i>Arthur S. Kraus</i> | |

MEDICAL CERTIFICATION

BP

• 1999 • 216

VS A15 (4)
15M 9/58

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4169

CERTIFICATE OF DEATH

Reg. Dist. No. 04163

| | | | |
|--|-------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <i>Carroll</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Westminster</i> | | c. LENGTH OF STAY IN 1b <i>46 yrs.</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>RD #4</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <i>MARY LOUISE STONESIFER</i> | | 4. DATE OF DEATH Month Day Year <i>APRIL 9 1961</i> | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <i>Dec. 9 1914</i> |
| 9. AGE (In years last birthday) yrs. <i>46</i> | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>factory worker</i> | | 12. KIND OF BUSINESS OR INDUSTRY <i>Canning factory</i> | |
| 13. BIRTHPLACE (State or foreign country) <i>Westminster, Carroll Md.</i> | | 14. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 15. FATHER'S NAME <i>Christian G. Wike</i> | | 16. MOTHER'S MAIDEN NAME <i>Emma H. Antz</i> | |
| 17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 18. SOCIAL SECURITY NO. <i>217-18-7537</i> | |
| 19. INFORMANT Address <i>Mrs. Chas. E. Eyster, Westminster RD #4 Md.</i> | | 20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Epidermoid carcinoma of Cervix</i>
171X DUE TO <i>Grade IV</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>metastatic carcinoma pelvic organs</i>
DUE TO (c) <i></i> | |
| 21. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 22. INTERVAL BETWEEN ONSET AND DEATH <i>6 Mon</i>
<i>3 Mon</i> | |
| 23. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 24. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 25. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | | 26. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 27. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 28. (City or town) (County) (State) | |
| 29. I certify that I attended the deceased from <i>March 20, 1951</i> , to <i>April 9, 1961</i> , that I last saw the deceased alive on <i>April 9, 1961</i> , and that death occurred at <i>11 P.M.</i> from the causes and on the date stated above. | | | |
| 30. ACTUAL SIGNATURE <i>W H Foard</i> M.D. | | 31. ADDRESS (Street, city or town, state) <i>Manchester, Md.</i> DATE SIGNED <i>4/10/61</i> | |
| 32. PHYSICIAN'S NAME (Type) <i>W H Foard MD.</i> | | 33. ADDRESS <i>Manchester, Md.</i> | |
| 34. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 35. DATE THEREOF <i>4/12/61</i> | |
| 36. NAME OF CEMETERY OR CREMATORY <i>Leisters Cemetery</i> | | 37. LOCATION (City, town, or county) (State) <i>Rural, Westminster, Md.</i> | |
| 38. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Myers, Jr.</i> | | 39. ADDRESS <i>Westminster, Md.</i> | |
| 40. REC'D BY REGISTRAR <i>APR 12 '61</i> | | 41. REGISTRAR'S SIGNATURE <i>Charles E. Myers</i> | |

CERTIFICATE OF DEATH

1169

(M)

1. Name of deceased: *John J. Smith*
2. Sex: *Male*
3. Age: *45*
4. Date of death: *Jan 15 1900*
5. Place of death: *Home*
6. Cause of death: *Heart Disease*
7. Signature of physician: *Dr. J. H. Smith*
8. Signature of registrar: *Wm. J. Smith*
9. Date of registration: *Jan 16 1900*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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4170
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04164

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Penna. b. COUNTY Adams | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural, Westminster | | c. LENGTH OF STAY IN 1b
1 Year | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Meadow View Convalescent Home Westminster, Md. R. D. 1 | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Catherine Middle Rose Last Thompson | | 4. DATE OF DEATH
Month April Day 5 Year 19 61 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 22, 1883 |
| 9. AGE (In years last birthday)
77 yrs. | | 10. IF UNDER 1 YEAR
Months 7 Days 7 Hours 7 Min. | 11. IF UNDER 24 HRS.
Months 7 Days 7 Hours 7 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own home | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John Schwartzkoph | | 14. MOTHER'S MAIDEN NAME
Bernadine Punte | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
None | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Evelyn C. Altoff | | Address 104 E. King St. Littlestown Pa. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Anterograde cardiac-vascular disease
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____ DUE TO
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
INTERVAL BETWEEN ONSET AND DEATH 5 years | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from April 19 5 , to April 5 19 61 , that (I) (we) last saw the deceased alive on April 4 19 61 , and that death occurred at _____ M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Leah Maitland | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
LEAH MAITLAND | | 22d. ADDRESS
Littlestown, Pa. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4/8/61 | |
| 23c. NAME OF CEMETERY OR CREMATORY
St. Aloysius Cemetery | | 23d. LOCATION (City, town, or county) (State)
Littlestown, Adams Co., Pa. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Richard A. Little | | 25a. REC'D BY REGISTRAR
DATE APR 10 '61 | |
| ADDRESS
Littlestown Pa. | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Knaus | |

01104

MARYLAND DEPARTMENT OF HEALTH
BUREAU OF VITALS
CERTIFICATE OF DEATH

4170



Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to the quality of the scan.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/59

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4171

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04165

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <i>Carroll</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Sykesville</i> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster, Rural</i> | | | |
| c. LENGTH OF STAY IN 1b <i>2 mo.</i> | | | | d. STREET ADDRESS <i>Reese</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Near Winfield</i> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <i>MARY</i> Middle <i>RUTH</i> Last <i>TRACY</i> | | | | 4. DATE OF DEATH Month <i>April</i> Day <i>23</i> Year <i>1961</i> | | | |
| 5. SEX <i>female</i> | | 6. COLOR OR RACE <i>white</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>June 23 1898</i> | |
| 9. AGE (In years lost birthday) <i>62</i> yrs. | | 10. KIND OF BUSINESS OR INDUSTRY <i>Drug store clerk</i> | | 11. BIRTHPLACE (State or foreign country) <i>Carroll Co. Md.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Benjamin Taylor</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Addie B. Blegiard</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> | | | | 16. SOCIAL SECURITY NO. <i>212-22-8037</i> | | 17. INFORMANT <i>M. T. Uppers</i> Address <i>572, Balto Blvd. Md.</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Exhaustion</i>
153.9 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Starvation</i>
DUE TO (c) <i>Cancer of intestine</i>
INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>no</i> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>no</i> | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. <i>X</i> p. m. <i>19</i> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>X</i> | |
| 20f. (City or town) <i>X</i> (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>2-23-1961</i> to <i>4-23-1961</i> , that (I) (we) last saw the deceased alive on <i>4-22-1961</i> and that death occurred at <i>3:30</i> M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <i>W. E. Stone</i> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <i>4-24-61</i> | |
| 22c. PHYSICIAN'S NAME (Type) <i>W. E. Stone</i> | | | | 22d. ADDRESS <i>1215 Grady St Westminster Md</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE THEREOF <i>4/25/61</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>St. Paul's Cemetery</i> | | 23d. LOCATION (City, town, or county) (State) <i>Rural Hampstead Md.</i> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>J. S. Myers, Jr.</i> | | | | ADDRESS <i>Westminster, Md</i> | | 25a. REC'D BY REGISTRAR <i>APR 28 '61</i> | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kinas</i> | |

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CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04167

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Carroll</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sikeston</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u>
b. COUNTY <u>Frederick</u> | |
| c. LENGTH OF STAY IN 1b <u>4 m - 1 w 7 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u> | | d. STREET ADDRESS <u>1011-2</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Florian</u> Middle <u>Verbanic</u> Last <u>Verbanic</u> | | 4. DATE OF DEATH Month <u>April</u> Day <u>14</u> Year <u>1961</u> | |
| 5. SEX <u>M.</u> | 6. COLOR OR RACE <u>W.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4-7-83</u> |
| 9. AGE (In years last birthday) <u>78</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Quarry Worker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>—</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Charles Verbanic</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> | | 16. SOCIAL SECURITY NO. <u>unknown</u> | |
| 17. INFORMANT <u>Records of Springfield St. Hosp.</u> | | Address <u>—</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial infarction</u>
DUE TO <u>Generalized atherosclerosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u>
DUE TO (c) <u>—</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.B.S. Assoc. with cerebral atherosclerosis</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12-7-60</u> to <u>4-14-61</u> , that (I) (we) last saw the deceased alive on <u>4-14-61</u> , and that death occurred at <u>6 PM</u> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Myron Nizankowsky</u> | | 22b. DATE SIGNED <u>4-15-1961</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>MYRON NIZANKOWSKY</u> | | 22d. ADDRESS <u>Springfield St. Hosp.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>4-17-1961</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Frederick Memorial Park</u> | 23d. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Bailey</u> | | 25a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u> | |
| ADDRESS <u>Frederick, Maryland</u> | | DATE <u>APR 19 '61</u> | |

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1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 26

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 04168

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Carroll | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural--Harrisville | | c. LENGTH OF STAY IN 1b
2 Yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural--Harrisville | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
P. O. Mt. Airy | | | | d. STREET ADDRESS
P. O. Mt. Airy | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) CLARENCE H. WAGNER | | | | 4. DATE OF DEATH
Month April Day 9 Year 1961 | | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
August 23, 1887 | | | |
| 9. AGE (In years last birthday)
73 yrs. | | IF UNDER 1 YEAR
Months 73 Days 0 Hours 0 Min. 0 | | IF UNDER 24 HRS.
Hours 0 Min. 0 | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Trackman--B. & O Railroad, Retired | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Maryland | | 11. BIRTHPLACE (State or foreign country)
U. S. A. | | | |
| 13. FATHER'S NAME
George Wagner | | | | 14. MOTHER'S MAIDEN NAME
Effie Horton | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) --- | | | | 16. SOCIAL SECURITY NO.
705-10-2002 | | | | | |
| 17. INFORMANT
Mr. Irvin Wagner, R.D. 3, Mt. Airy, Md. | | | | Address --- | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis
DUE TO Coronary Sclerosis
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. obesity
DUE TO obesity
(b) obesity
(c) obesity
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
--- | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Sudden
Several yrs | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
--- | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
--- | | 20f. (City or town) (County) (State)
--- | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE Wesley H. Speichers | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| EXAMINER'S NAME (Type) Wesley H. Speichers | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
4-12-1961 | | 22c. NAME OF CEMETERY OR CREMATORY
Pine Grove Cemetery | | 22d. LOCATION (City, town, or county) (State)
Mt. Airy, Maryland | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
C. M. Waltz, Winfield, Maryland | | | | 24a. REC'D BY REGISTRAR
APR 11 '61 | | 24b. REGISTRAR'S SIGNATURE
C. M. Waltz | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
4175
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04169

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH
o. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Balto. City | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 2 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Springfield State Hospital | | d. STREET ADDRESS
613 E. Baltimore Street | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Eli Middle Houck Last Walters | | 4. DATE OF DEATH
Month April Day 11 Year 1961 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
August 8, 1911 |
| 9. AGE (In years last birthday)
49 yrs. | | IF UNDER 1 YEAR: Months 4 Days 11 Hours 11 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY
- | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Andrew Walters | | 14. MOTHER'S MAIDEN NAME
Sally Marsh | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
- | |
| 17. INFORMANT
Springfield Hospital Records. | | Address | |

| | | | |
|---|--|---|--|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
443 X IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) -
DUE TO (c) - | | INTERVAL BETWEEN ONSET AND DEATH
Years. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Inadequate personality and alcoholism. | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Feb. 17, 1961 to April 11, 1961 , that (I) (we) last saw the deceased alive on April 11, 1961 , and that death occurred at 10:55 PM from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Agustin del Campo | | 22b. DATE
4/12/61 | |
| 22c. PHYSICIAN'S NAME (Type)
Agustin del Campo, M.D. | | 22d. ADDRESS
Springfield Hospital, Sykesville, Md. | |

| | | | | | | | |
|---|--|-------------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4-13-61 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Vincent (Sacred Heart) | | 23d. LOCATION (City, town, or county) (State)
Balto. Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
John G. Connelly | | | | ADDRESS
418 Eastern Blvd. 21 | | 25a. REC'D BY REGISTRAR
APR 14 '61 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Charles S. Hume | | | |

WEST VIRGINIA STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS AND STATISTICS
CERTIFICATE OF DEATH

3175

(M)

03160

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Date of death: _____

7. Place of death: _____

8. Cause of death: _____

9. Signature of physician: _____

10. Signature of registrar: _____

11. Date of registration: _____

12. Registrar's name: _____

13. Registrar's address: _____

14. Registrar's telephone: _____

15. Registrar's office: _____

16. Registrar's title: _____

17. Registrar's signature: _____

18. Registrar's date: _____

19. Registrar's name: _____

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197. Registrar's office: _____

198. Registrar's title: _____

199. Registrar's signature: _____

200. Registrar's date: _____

01170

CERTIFICATE OF DEATH

1170

M

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
4177
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04171

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Carroll | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Keysville - Rural | | c. LENGTH OF STAY IN 1b
4 Months | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
P.O. Key MAR. | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural--Sykesville | |
| 3. NAME OF DECEASED (Type or print)
First MILLIE Middle E. Last WAMPLER | | 4. DATE OF DEATH
Month April Day 5 Year 1961 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Oct. 11, 1872 |
| 9. AGE (In years last birthday)
88 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Domestic | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Luther M. Wampler | | 14. MOTHER'S MAIDEN NAME
Alice Jane Shoemaker | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Miss Mary A. Wampler, Keysville, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Arteriosclerotic Nephritis
442X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Myocarditis + Myocardial Degeneration
INTERVAL BETWEEN ONSET AND DEATH
5 yrs
15 yrs | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | |
| 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 2/21 19 61 , to 4/5 19 61 , that (I) (we) last saw the deceased alive on 4/5 19 61 , and that death occurred 11:45 P. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
R. S. McVaugh | | | |
| 22b. DATE SIGNED | | | |
| 22c. PHYSICIAN'S NAME (Type)
R. S. McVaugh | | | |
| 22d. ADDRESS
Taneytown, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | |
| 23b. DATE THEREOF
4-8, 1961 | | | |
| 23c. NAME OF CEMETERY OR CREMATORIUM
Messiah Lutheran | | | |
| 23d. LOCATION (City, town, or county) (State)
Carroll, Maryland | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
C. M. Waltz, Winfield, Maryland | | | |
| 25a. REC'D BY REGISTRAR
DATE APR 7 '61 | | | |
| 25b. REGISTRAR'S SIGNATURE
Arthur L. Kline | | | |

CERTIFICATE OF DEATH

0177

0177

MADE BY THE STATE DEPARTMENT OF HEALTH
FOR THE PURPOSE OF RECORDING THE DEATH OF A PERSON
WHO HAS DIED IN THE STATE OF NEW YORK

Decedent

Married

Age

Sex

(M)

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

Place of Birth

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4178
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04172

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY — | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural - Sykesville | | | | c. LENGTH OF STAY IN 1b
2yr. 6mos. 6days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore City (Zone 14) | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
SPRINGFIELD STATE HOSPITAL | | | | d. STREET ADDRESS
3209 Northway Drive | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Ivy Middle Estelle Last WHITE | | | | 4. DATE OF DEATH
Month APRIL Day 12 Year 1961 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
7-18-88 | |
| 9. AGE (In years last birthday)
72 yrs. | | IF UNDER 1 YEAR
Months Days Hours | | IF UNDER 24 HRS.
Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Sewing Machine Operator | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
United States | | | | | | | |
| 13. FATHER'S NAME
George Coleman | | | | 14. MOTHER'S MAIDEN NAME
Virginia Satterfield | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
220-14-9600 | | 17. INFORMANT
Hospital Records | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last.
(b) Arteriosclerotic Heart Disease
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Plus late latent syphilis.
CBS assoc. with senile brain disease, with psychotic reaction. | | | | INTERVAL BETWEEN ONSET AND DEATH
24 hrs.
Years | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that He (this hospital) attended the deceased from 10-6 , 19 58 , to 4-12 , 19 61 , that (1) He last saw the deceased alive on April 12 , 19 61 , and that death occurred at 3:30 PM, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Ilse Kamm | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
4-12-61 | |
| 22c. PHYSICIAN'S NAME (Type)
Ilse Kamm, M. D. | | | | 22d. ADDRESS
Springfield State Hospital - Sykesville | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
4-15-61 | | 23b. DATE THEREOF
4-15-61 | | 23c. NAME OF CEMETERY OR CREMATORY
Wesley Chapel | | 23d. LOCATION (City, town, or county) (State)
Rock Hall - Md | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Ruck, Lemay | | | | ADDRESS 5805 Harford | | 25a. REC'D BY REGISTRAR
DATE 2/12/61 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Kneiss | |

04178

CERTIFICATE OF DEATH

04178

W

1

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
M
4179
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
04173

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesville | | c. LENGTH OF STAY IN 1b
24 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Springfield State Hospital | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Vale Summit | |
| 3. NAME OF DECEASED (Type or print)
First Agnes Middle Ruth Last Phillips Winters | | 4. DATE OF DEATH
Month April Day 11 , Year 19 61 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
August 17, 1892 |
| 9. AGE (In years lost birthday)
68 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
- | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
William Edward Phillips | | 14. MOTHER'S MAIDEN NAME
Nova Ross | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
- | |
| 17. INFORMANT
Springfield Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Mitral stenosis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost.
(b) Rheumatic heart disease
DUE TO
(c) Multiple emboli to lungs and brain with softening.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)
Chronic brain syndrome. | | | |
| INTERVAL BETWEEN ONSET AND DEATH
Years
Months & days. | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from March 17, 1961 to April 11, 1961 , that (I) (we) last saw the deceased alive on April 10, 1961 , and that death occurred at 5:15 AM from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Agustin del Campo | | 22b. DATE
4/11/61 | |
| 22c. PHYSICIAN'S NAME (Type)
Agustin del Campo, M.D. | | 22d. ADDRESS
Springfield Hospital, Sykesville, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
4-14-61 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Loar Cemetery | | 23d. LOCATION (City, town, or county) (State)
Loartown Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Charles Logsdon | | 25a. REC'D BY REGISTRAR
APR 19 '61 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | |

